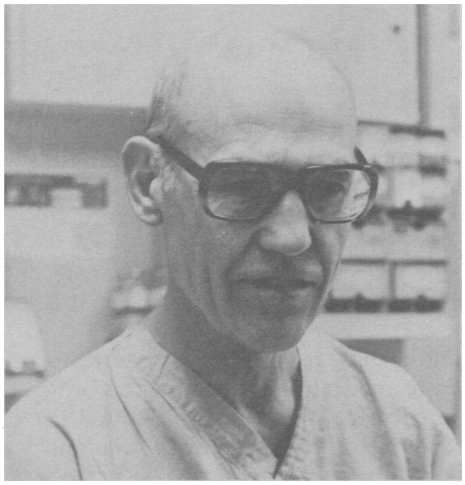
**More Economical for Patients**

# Surgeon Advocates More Office-Based Surgery

Dr. David R. Davis of Bellevue would like to see more surgeons perform hernia repairs and other minor surgery in their own offices, rather than in the hospital. In fact, his goal is to convince his colleagues that such office-based surgery should be the norm, rather than the exception.

Dr. Davis, president-elect of the King County Medical Society, has had plenty of personal experience with office-based surgery. A board-certified surgeon, he performs hernia repairs, breast biopsies, pilonidal sinus excisions, varicose vein excisions, and scalene node and axillary node biopsies in his office. Over the past five to six years, he estimates he has performed more than 1,000 such procedures in his office without mishap. He's quick to say that all the surgeons in Bellevue have done some of these procedures in the office for as long as 15 years, but the idea of doing hernia repairs in the office has never really caught on with most surgeons.



*Dr. David R. Davis*

Dr. Davis did his first hernia repair in his office for a man "who was just barely making it financially," he says. "He couldn't afford the cost of hospitalization, and his hernia was really bugging him. So, I told him I'd repair it for him in my office for free."

Then, he did a few repairs on patients who were very fearful of hospitalization, and in the past two years he has tried to do all hernia repairs in the office.

He didn't perform inguinal hernia repairs routinely in his office earlier in his career, he says, "simply because it didn't occur to me that it could be done so successfully."

Saving the patient money on hospitalization really delights Dr. Davis. "I was a Depression-reared kid, and I just can't see spending money for anesthesia, operating room and recovery room when the patient doesn't need it," he explains. "If surgical residents were trained to do office-based surgery, it could save millions of dollars a year."

His office in Bellevue, only a few feet from Overlake Hospital, contains two rooms equipped for surgery. A simple operating table stands in the middle of each one and resuscitation equipment and drugs are close at hand.

He starts most procedures by sedating the patient with an injection of Valium and Demerol. He then administers bupivacaine, a long-acting local anesthetic. Instead of using electrical monitors, "I just keep talking to the patient and make sure he's talking back," he comments.

His most useful tool is his hand-controlled electrocautery device that keeps blood loss almost to zero, he reports. He doesn't use surgical gowns and keeps draping to a minimum.

He is a strong proponent of doing breast biopsies as a separate procedure under local anesthesia in an office setting. "Rather than the patient having to face the prospect of waking up from a biopsy with a breast missing, we can do the biopsy, get the results and then have time to sit down and work out strategies," he explains.

Patients easily accept the idea of having surgery in the office, he says. At least part of the reason, he believes is because "I'm a very reassuring kind of guy—I try to make it seem to the patient that it's a very natural thing to do. If I were timorous, I'm sure that would be communicated to patients instantly." He thinks his reassuring manner also has contributed to his success in using local anesthesia. "Most reactions to anesthesia are fright reactions, rather than allergic reactions," he asserts.

After the procedure, the patient, driven by someone else, goes home for recovery. Dr. Davis provides a detailed written explanation of what to expect post-op as well as appropriate medications. He encourages the patient to call if a problem arises; he has received no such calls to date.

Within 24 hours of surgery, Dr. Davis telephones the patient to check on his or her condition. Surprisingly, he has never had a case of urinary retention, one of the more common problems arising after hernia repairs done under general or spinal anesthesia. Normally, patients are seen in his office about a week later for followup care.

Because he is very busy with referrals from family physicians, internists and patients, Dr. Davis expects other surgeons in the area to begin doing more surgery in their offices "for competitive reasons," he says. However, at this stage, he worries that if something were to happen to one of his patients, "I'd be crucified by my peers. Nobody is comfortable with change," he says. "It's easier to maintain the status quo. But, doctors can't wait for lawyers to make changes in the 'standard of practice.' Somebody has to make the move away from defensive, expensive procedures—to an equally effective, cheaper method."

He firmly believes that office-based surgery is the wave of the future because of continuing pressure to make medical care relatively less expensive. His conclusion: "Other surgeons should try it. They'll like it." □

## Average Hospital Stay Nearly $2,000

The average hospital stay in the state now costs $1,975 or $362 per day and the average length of stay is 5.45 days, according to a recently issued report by the Washington State Hospital Commissibn. The cost is up nearly 17 percent from last year.

The cost includes room, nursing care, housekeeping and other services such as x-ray, laboratory, surgical and other supplies, plus depreciation on equipment and buildings. It does not include physicians' fees.

According to Frank Baker, executive director of the commission, a major factor in the increase in cost is the underpayment of hospital charges by Medicare and Medicaid; the underpayment is up nearly 50 percent from last year.

Hospital construction costs, up nearly $14 million from the 1980 level after adjusting for inflation, were listed as another major factor in the higher rates. □